Background

- Code Section 223: An individual is eligible to contribute to a Health Savings Account (HSA) only if he or she is enrolled in a qualified high deductible health plan and does not have any other disqualifying coverage.

- Notice 2008-59: If an employer pays for medical care other than the following before an individual reaches the HDHP deductible, the individual is not eligible to contribute to an HSA:
  - Coverage for dental care, vision care, long-term care, accidents, or disability
  - Preventive care
PREVENTIVE CARE
Preventive Care

- **ACA Preventive Care** → Category of services that group health plans (incl. but not limited to HDHPs) are required to cover at no cost under the Patient Protection and Affordable Care Act ("ACA")

- **HDHP Preventive Care** → Services that an HDHP may, but does not have to, provide at no cost on a pre-deductible basis
Before IRS Notice 2019-45, HDHP Preventive Care Includes:

- ACA Preventive Care
- Services that qualify as preventive under the SSA
- Preventive care as defined in IRS guidance – specifically IRS Notice 2004-23 and Notice 2004-50
  - Generally does not include any service or benefit intended to treat an existing illness, injury, or condition.
  - Limited exceptions (e.g., treatment incidental to preventive screening; medication to prevent onset/recurrence of condition that hasn’t developed or from which the person has recovered)
    - Treatment of high cholesterol to cholesterol-lowering medications (e.g., statins) to prevent heart disease
    - Treatment of recovered heart attack or stroke victims with ACE inhibitors to prevent a reoccurrence.
Expanded Interpretation of Preventive Care for HDHPs

- IRS Notice 2019-45
- Effective July 17, 2019
- Certain items and services used to prevent exacerbation of an existing chronic condition (e.g., diabetes) *can* be treated as preventive care under a high deductible health plan. – i.e., plans can now cover expanded preventive care services at 100% without interfering with HSA eligibility.
- Permissive, not required.
Listed benefits can be paid at 100% under an HDHP if:

- Prescribed to treat an individual diagnosed with specified condition
- For the purpose of preventing the exacerbation of the chronic condition or the development of a secondary condition

<table>
<thead>
<tr>
<th>Preventive Care for Specified Conditions</th>
<th>For Individuals Diagnosed with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Angiotensin Converting Enzyme (ACE) inhibitors</td>
<td>Congestive heart failure, diabetes, and/or coronary artery disease</td>
</tr>
<tr>
<td>Anti-resorptive therapy</td>
<td>Osteoporosis and/or osteopenia</td>
</tr>
<tr>
<td>Beta-blockers</td>
<td></td>
</tr>
<tr>
<td>Blood pressure monitor</td>
<td>Congestive heart failure and/or coronary artery disease</td>
</tr>
<tr>
<td>Inhaled corticosteroids</td>
<td>Hypertension</td>
</tr>
<tr>
<td>Insulin and other glucose lowering agents</td>
<td>Asthma</td>
</tr>
<tr>
<td>Retinopathy screening</td>
<td>Diabetic</td>
</tr>
<tr>
<td>Peak flow meter</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Glucometer</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Hemoglobin A1c testing</td>
<td>Diabetic</td>
</tr>
<tr>
<td>International Normalized Ratio (INR) testing</td>
<td>Liver disease and/or bleeding disorders</td>
</tr>
<tr>
<td>Low-density Lipoprotein (LDL) testing</td>
<td>Heart disease</td>
</tr>
<tr>
<td>Selective Serotonin Reuptake Inhibitors (SSRIs)</td>
<td>Depression</td>
</tr>
<tr>
<td>Statins</td>
<td>Heart disease and/or diabetes</td>
</tr>
</tbody>
</table>
Can Any Other Drugs Be Considered Preventive Care?

- “The Treasury Department and the IRS, in consultation with HHS, have determined that certain medical care services received and items purchased, including prescription drugs, for certain chronic conditions should be classified as preventive care for someone with that chronic condition. These medical services and items are limited to the specific medical care services or items listed in the attached Appendix for the chronic conditions specified in the Appendix. In making this determination, the Treasury Department and IRS are exercising the Secretary’s authority under section 223(c)(2)(C).”

- “These criteria were used in determining the particular services and items listed in the Appendix, but this notice does not expand the scope of preventive care beyond the list. Therefore, services or items that meet (or may meet) the criteria but are not on the list are not treated as preventive care as a result of this notice or on any other basis (but see the Effect On Other Documents section of this notice regarding the continued applicability of previous guidance).”

- “Any services and items that constitute preventive care under the guidance in Notice 2004-23, Notice 2004-50, and Notice 2013-57 continue to be treated as preventive care for purposes of section 223.”
PBM Preventive Drug List

- Assume that a PBM’s preventive drug list interpreted Notice 2004-50 to include drugs that were described in Notice 2019-45.

- Notice 2019-45 indicates that it represents an expansion of the list of qualifying preventive care benefits

- Does that result suggest that the PBM’s interpretation of Notice 2004-50 was incorrect? Has the PBM reevaluated in light of Notice 2019-45?

- How can an employer without a medical background ensure that the plan covers only preventive care?

PBM Interpretation of Notice 2004-50

Notice 2019-54
### Comparing Guidance

<table>
<thead>
<tr>
<th>Notice 2004-50</th>
<th>Notice 2019-45</th>
<th>Sample PBM List</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of high cholesterol with cholesterol-lowering medications (e.g., statins) to prevent heart disease</td>
<td>Statins for heart disease and/or diabetes</td>
<td>Statins</td>
</tr>
<tr>
<td>Treatment of recovered heart attack or stroke victims with ACE inhibitors to prevent a reoccurrence.</td>
<td>ACE inhibitors for congestive heart failure, diabetes, coronary artery disease</td>
<td>ACE inhibitors</td>
</tr>
</tbody>
</table>
COPAY ASSISTANCE
Drug Manufacturer Assistance

Scenario

– Employee is prescribed a drug that would generally cost $500 under the terms of the employer’s health plan

– Employee qualifies for financial assistance from the manufacturer
  • Manufacturer pays $400
  • Employee pays $100

Question:

– May the manufacturer assistance be excluded from the out-of-pocket maximum

– Must the manufacturer assistance be excluded from the deductible and/or out-of-pocket maximum
Background

- The ACA requires non-grandfathered group health plans to accumulate certain amounts toward the out-of-pocket maximum.
- The Internal Revenue Code requires high deductible health plans to accumulate certain amounts toward the deductible and out-of-pocket maximum.
2019 Guidance

- Final rule on drug manufacturer coupons included in HHS Notice of Benefit and Payment Parameters for 2020 (Apr. 25, 2019)
  - For Plan years beginning after Jan. 1, 2020, plans are permitted to exclude the value of drug manufacturer’s coupons from counting toward the annual limit on cost sharing (OOPM) when a medically appropriate generic equivalent is available
  - Differing opinions as to how to interpret the rule with respect to other circumstances (e.g., coupon for brand drug where no generic equivalent)
    - Language in preamble implied that plans are required in all other cases to count the coupon amount toward the OOPM for drugs that are essential health benefits

- ACA FAQ Part 40 (Aug. 26, 2019)
  - HHS announces delay of enforcement, with plans to address the matter in the Notice of Benefit and Payment Parameters for 2020
Exclusion of Drug Coupons from HDHP Deductible Accumulation

“The Departments note that such a requirement could create a conflict with certain rules for high deductible health plans (HDHPs) that are intended to allow eligible individuals to establish a health savings account (HSA). Specifically, Q&A-9 of IRS Notice 2004-50 states that the provision of drug discounts will not disqualify an individual from being an eligible individual if the individual is responsible for paying the costs of any drugs (taking into account the discount) until the deductible of the HDHP is satisfied. Thus, Q&A-9 of Notice 2004-50, requires an HDHP to disregard drug discounts and other manufacturers’ and providers’ discounts in determining if the minimum deductible for an HDHP has been satisfied and only allows amounts actually paid by the individual to be taken into account for that purpose. Such a requirement could put the issuer or sponsor of an HDHP in the position of complying with either the requirement under the 2020 NBPP Final Rule for limits on cost sharing in the case of a drug manufacturer coupon for a brand name drug with no available or medically appropriate generic equivalent or the IRS rules for minimum deductibles for HDHPs, but potentially being unable to comply with both rules simultaneously.”